CARER APPLICATION FORM

Perfect Quality Care Ltd

Excellent Tailored Care

CARE STAFF APPLICATION FORM

PLEASE FILL THIS APPLICATION FORM USING CAPITAL LETTERS AND RETURNED TO THE ABOVE ADDRESS

PERSONAL DETAILS

Title MR MRS MISS MS DR OTHER

* Forename:		Age:	
* Middle Name:		* National Insurance No.	
* Surname:		* Mobile Number:	
* Date of Birth:		Work Phone:	
* Marital Status:		* Email:	

* First Line Address:	
Second Line Address:	
* City / Town:	
* Country:	
* Postcode:	

Preferred Contact Method:
Email Phone Post Text
Call expectancy:
Morning Night Both

VARIOUS INFORMATION

Work Status:		Nationality:	
Home Office Letter Ref:		Work Permit:	
Permit Type:		Expiration Date:	

Passport Number:		Expiration Date:	
Birth Certificate No.:			

Name of College / University (if student):	

Have your own transport:	Yes No	Type of Transport:	
Do you have a driving license:	Yes No	Any endorsement:	

Religion:		Ethnic Origin:	
Other:		Other:	

Children Under 18 Years?: Yes No		Ages
1.		
2.		
3.		
4.		

Do You smoke? Yes No Registered Disabled Yes No

Registration No.	

Give Details of Hobbies / Leisure Activities:

PROFESSIONAL EDUCATION & TRAINING

PLEASE LIST ANY TRAINING / COURSE / HEALTHCARE QUALIFICATION YOU HAVE AND WHEN YOU GAINED THEM

Qualification	School / College University	Dates

PLEASE TICK THE SPECIALITIES OF WHICH YOU HAVE SIGNIFICANT, POST TRAINING EXPERIENCE. PLEASE REMEMBER YOU ARE HELD ACCOUNTABLE FOR ANY MISSING INFORMATION.

SPECIALITIES	LESS THAN 6 MONTHS	MORE THAN 6 MONTHS	1- 2 YEARS	2 YEARS +
Hospitals				
Learning Disability				
Adolescents				
Children				
Mental health				
Elderly				
Physical disability				
HIV				
Residential Homes				
Nursing homes				
Others				

EMPLOYMENT HISTORY

PLEASE GIVE DETAILS OF YOUR PAST 5 YEARS OF CONTINUOUS WORK HISTORY GIVING REASONS/S FOR ANY BREAKS IN EMPLOYMENT.

1.

Employer	*Date From:*	*Date To:*
Address:		
Post code:		
Contact number:	Email:	

Main Responsibilities:

Reasons for leaving:

2.

Employer	*Date From:*	*Date To:*
Address:		
Post code:		
Contact number:	Email:	

Main Responsibilities:

Reasons for leaving:

3.

Employer		*Date From:*	*Date To:*
Address:			
Post code:			
Contact number:		Email:	
	Main Responsibilities:		
	Reasons for leaving:		

4.

Employer		*Date From:*	*Date To:*
Address:			
Post code:			
Contact number:		Email:	
	Main Responsibilities:		
	Reasons for leaving:		

HEALTH DECLARATION

HAVE YOU BEEN VACCINATED OR TESTED AGAINST THE FOLLOWING?:	YES	NO	DETAILS (PLUS DATES IF YES)
Hepatitis B	Yes	No	
HIV	Yes	No	
Tetanus	Yes	No	
Poliomyelitis	Yes	No	
Typhoid	Yes	No	
Tuberculosis And BCG	Yes	No	
Hepatitis B Antibodies	Yes	No	
Mantoux, Tine Or Heaf	Yes	No	
Varicella	Yes	No	
Last X-Ray	Yes	No	
Others (Specify)	Yes	No	
DO YOU OR HAVE YOU AT ANY TIME SUFFERED FROM ANY OF THE FOLLOWING?	**YES**	**NO**	**DETAILS (PLUS DATES IF YES)**
Skin Complaints- Dermatitis, Psoriasis, Eczema	Yes	No	
Diabetes Or Glandular Complaints	Yes	No	
Headaches Or Migraine	Yes	No	
Hypertension/ Heart Problems/ Similar Illness	Yes	No	
Back Pains / Back Injury Or Problems	Yes	No	
Jaundice / Hepatitis	Yes	No	
Epilepsy Or Fainting Attacks	Yes	No	
Pleurisy /Bronchitis / Pneumonia	Yes	No	
Asthma	Yes	No	
Infections - Ear / Sore Throat	Yes	No	
Psychiatric Illness - Mental Disorder/ Depression etc	Yes	No	
AT PRESENT ARE YOU HAVING ANY INJECTIONS/MEDICATIONS	**YES**	**NO**	**DETAILS (PLUS DATES IF YES)**

Are you under any treatment of any kind of condition?	Yes	No	
Have you had any major operations	Yes	No	
Physical disabilities?	Yes	No	
How much time have you taken off Work in the last 5 years due to illness?.	Yes	No	
please state any other information about your health which may affect your work	Yes	No	

IF YOU DO NOT HAVE VACCINATION INFORMATION , PLEASE PROVIDE DETAILS OF WHERE WE CAN REQUEST THEM BELOW.

I Certify the above information is correct and hereby give permission to **Perfect Quality Care** to request a further report from my GP/ Occupational Health/ Hospital for clarification if required and for my health report.

GP / Occupational Health / Hospital:

Address:			
Tel:		Mobile:	
Email:			

SIGNATURE (APPLICANT):____

WORK PREFERENCES

PLEASE SPECIFY THE KIND OF CARE WORK YOU ARE INTERESTED IN? (TICK ALL THAT APPLY)

NHS | Private Hospital | Nursing Home | Residential Home

Others: | Short Term | Long Term

PLEASE INDICATE WHEN YOU WOULD LIKE TO WORK. PLEASE TICK ALL RELEVANT BOXES.

DAILY:

Part-Time: | Full-Time: | Bank Holidays:

Evenings (M-F): | Days (M-F): | Nights (M-F):

Evenings (Sat-Sun): | Days (Sat-Sun): | Nights (Sat-Sun):

AVAILABILITY:

From when are you available to work?:

Date available for interview?:

Do you have any holiday booked? If yes, when?

REHABILITATION OF OFFENDERS ACT 1974

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore, not entitled to withhold information about convictions, which for other purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Information provided will be kept confidential and use in relationship to the post applied for.

Have you ever been convicted of a criminal offence? Yes No

If yes, please specify:

Do you have any spent or unspent convictions? Yes No

If yes, please specify:

Have you instigated an enhanced disclosure within the last six years?

Yes No

I consent to **Perfect Quality Care** checking the details I have provided against the various data sources in order to verify my identity and process this application. These details maybe use to assist other organisation such as DBS checks, in identity purposes.

Signature____Date:_____________________

REFERENCES

Please give the names and addresses of two of your most recent employers with work addresses who can comment on your work ability and experience. Starting with your present to most recent employer if possible.

1.

Name of Reference:			
Company's Name:			
Address:			
Postcode:		City / Town	
Country		Tel:	
Mobile:		Email Address:	
Start Date:		End Date:	

2.

Name of Reference:			
Company's Name:			
Address:			
Postcode:		City / Town	
Country		Tel:	
Mobile:		Email Address:	
Start Date:		End Date:	

BUILDING SOCIETY /BANK DETAILS

Bank Name:			
Bank Address:			
Building Society Bank Roll:			
Account Holder's Name:			
Sort Code:		Account No:	

I authorise perfect quality care to pay my weekly wages into the above bank account and I will notify PERFECT QUALITY CARE if changes occur to my details.

Signature____**Date:**_____________________

NEXT OF KIN

Name of Emergency Contact:		**Relationship:**	
Address:		Postcode	
Mobile:		Home Phone:	
Email:			

WORKING TIME REGULATIONS

ACCORDING TO THE WORKING TIME REGULATIONS

- You are not required to work more than 48 hours per week except agreed in writing.
- An Agency staff is entitled to 11 hours rest from work in each 24 hours and 12 hours if under 18 years.
- A minimum of 20 minutes break when the working day is longer than 6 hours.
- Staff should not work 8 hours in every 24 hours if it is night work.
- Staff is entitled to a minimum of 1 day rest from work each week or 2 days every 2 weeks.
- Staff is entitled to 4 weeks paid annual leave once they have worked through a particular agency for a continuous 13 weeks period.

I have read and understood the **WORKING TIME REGULATIONS** and I hereby consent that the working time limit shall not apply to my assignments.

Print Name:____

Signature:____Date:____________________________

FINAL STATEMENT

I declare that the information provided on this application is true to the best of my knowledge. I have read the terms and condition of engagement and agree to comply with the current health and safety at work act. I understand that my appointment is subject to the receipt of two satisfactory references and it subject to **ENHANCED DBS DISCLOSURE**. **PERFECT QUALITY CARE** is free to make any other enquiries they may find necessary relating to my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to.

Signature:____Date:_________________________

AGENCY INFORMATION- OFFICE USE

CHECKLIST	WHAT HAVE YOU SENT	NOTES
Application		
Proof of Address		
Proof of identity		
Eligibility to work		
DBS Application		
PAYE Form		
2 Passport Photograph		
Immunisation		
Signed contract		

AGENCY SIGN OFF

I Certify that I interviewed the above applicant in accordance with the **Perfect Quality Care** requirements and I am satisfied that this applicant is cleared for work.

Name of Consultant:____

Signature:____Date:________________